This form may be completed online, printed and mailed to the address listed below.

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
CREDENTIALING DIVISION
P.O. Box 94986
Lincoln, Nebraska 68509-4986

APPLICATION FOR LICENSURE AS AN AUDIOLOGIST OR SPEECH-LANGUAGE PATHOLOGIST

SECTION A – Personal Information (All applicants for licensure must complete this section)				
1	Name	First:	Middle:	Last:
2	Present Address	Street/PO/Route:		
		City:	State:	Zip:
3	Home Phone (Optional)			
4	Social Security Number			
5	Date of Birth			

(**Attach a notarized copy of your birth certificate, marriage license, driver's license or other valid verification of age)**

6	Place of Birth	(City/Country/State)	
7	**Moral Character:**		
	a	Have you been convicted of a misdemeanor or felony other than a minor traffic violation? **Answer Yes or No**	
	b	Has your license in any health care profession in another state been revoked, suspended, limited or disciplined in any manner? **Answer Yes or No**	

If you answered **YES** to the above, you must request the following documents be sent directly to this office:

- Official Court Record, which includes charges and disposition
- If the conviction involved a drug and/or alcohol related offense, all addiction/mental health evaluations and proof of treatment (if treatment was obtained and/or required)
- If you are currently on probation, a letter from you probation officer addressing probationary conditions and your current status
- If your license in health care in another state has been revoked, suspended, limited or disciplined in any way, an official copy of the disciplinary action, including charges and disposition

Are you licensed or certified in another state? **Answer Yes or No**	
If yes, list state(s):	
Has any action ever been taken against your license/certificate or is there any pending disciplinary action? **Answer Yes or No**	

If yes, state date, type of action, and name and address of entity taking such action:

Type of Action	Date of Action	Name/Address of entity taking action

Attestation by the applicant:

1	Have you practiced in Nebraska prior to the application for a license? **Answer Yes or No**	
2	If yes, what are the actual number of days you practiced in Nebraska prior to licensure?	

SECTION B – Area of Licensure (All applicants for licensure must complete this section)			
☐	Audiology	☐	Speech-Language Pathology

SECTION C – License Application Category: All applicants for licensure must complete this section	
☐	By Education
☐	By Endorsement by the American Speech-Language-Hearing Association or Equivalent
☐	By License in Another Jurisdiction

Licensure Fee:

Determine the month and year in which you are submitting your application. If the month falls in the shaded area of the following chart, the fee for initial licensure is **$22**. If the month falls in the unshaded area, the fee for initial licensure is **$21.**

Year	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even	**$21**	**$21**	**$21**	**$21**	**$21**	**$21**	**$21**	**$21**	**$21**	**$21**	**$21**	**$22**
Odd	**$22**	**$22**	**$22**	**$22**	**$22**	**$22**	**$22**	**$22**	**$22**	**$22**	**$22**	**$21**

** If the license fee at the time the application is final is different from the fee at the time the application is submitted, the $1 difference will be requested or refunded.

SECTION D – Education: All applicants who are applying on the basis of education must list colleges and universities attended. Use additional paper if required. SUBMIT OFFICIAL TRANSCRIPTS FROM ALL SCHOOLS ATTENDED.

Name of Institution	Location	Dates Attended	Degree Obtained

SECTION E - Examination: Any applicant who is applying on the basis of education must submit official documentation of passing the licensure examination.

SECTION F - Clinical Fellowship Year (CFY): Any applicant who is applying on the basis of education must have his/her supervisor complete and submit the "Documentation of Completion of the Clinical Fellowship Year" form to the Credentialing Division. (Attachment A1)

SECTION G - Verification of Certificate of Clinical Competence from American Speech-Language-Hearing Association: All applicants who are applying on the basis of endorsement by the American Speech-Language-Hearing Association (ASHA (301) 897-5700) or equivalent must submit or have submitted official documentation of the Certificate of Clinical Competence to the Credentialing Division.

SECTION H - License Issued on Basis of a License in Another Jurisdiction: If you hold a license to practice Audiology and Speech-Language Pathology in another jurisdiction, complete this section and have the licensing agency complete the Certification of Applicant's License in Audiology or Speech-Language Pathology. (Attachment A3)

1	Name of agency issuing license			
	Address	Street/PO/Route:		
		City:	State:	Zip:
2	Date Issued:			
3	Name of written examination:			
4	Have you requested to have certification of your Audiology or Speech-Language Pathology license sent to Nebraska? (Attachment A4) **Answer Yes or No**			

SECTION I – Certification of Applicant

CERTIFICATION

I hereby certify that the preceding information is correct to the best of my knowledge and I further certify that I am of good moral character.

_____

Signature of applicant Date

ATTACHMENT A1

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
CREDENTIALING DIVISION
P.O. Box 94986
Lincoln, Nebraska 68509-4986

DOCUMENTATION OF COMPLETION OF THE CLINICAL FELLOWSHIP YEAR (CFY)

(You may make copies of this form.)

SECTION A – Supervisor Information (To be completed by supervisor)						
1	Name:					
2	Are you licensed in Nebraska? **Answer Yes or No**					
	2a	If yes, in what profession?	❑	Audiology	❑	Speech-Language Pathology
	2b	What is your license number?				
	2c	If no, in what state are you licensed?				
	2d	What is your license number?				
3	Do you have a Certificate of Clinical Competency from the American Speech - Language - Hearing Association? **Answer Yes or No**					
	3a	If yes, in what profession?	❑	Audiology	❑	Speech-Language Pathology
	3b	What is your Certificate number?				

Any supervisor who does not hold a valid Nebraska license or Certificate of Clinical Competency from the American Speech-Language-Hearing Association must submit documentation that he/she is eligible for licensure in Nebraska.

SECTION B – Clinical Fellowship Year Information: (To be completed by supervisor)						
1	Name of Clinical Fellow:					
2	Dates of Supervision:	From:		To:		
3	Name of Site:					
	Address	Street/PO/Route:				
		City:	State:	Zip:		
	Telephone Number (Optional)					
4	Area in which Clinical Fellow completed his/her Clinical Fellowship Year:					
	❑	Audiology	❑	Speech-Language Pathology		
	Clinical Fellow worked:	❑	Full Time	❑	Part Time	
	Number of hours worked per week:					

5	List date, site, and type of activity evaluated for the eighteen (18) onsite observations required for completion of the Clinical Fellowship Year. Acceptable types of activities include but are not limited to: assessment, diagnosis, evaluation, screening, habilitation, rehabilitation, and activities related to client management, e.g. client reports, client conferences, family counseling, etc.		
	Date	Site	Activity Observed
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

6	List date, site, and type of the other monitoring activities required for completion of the Clinical Fellowship Year. At least eighteen (18) activities (1 per month) must be listed and may include, but are not limited to: (a) Evaluating the Clinical Fellow's clinical records, including diagnostic reports, treatment records, correspondence, plans of treatment, and summaries of clinical conferences, (b) monitoring the Clinical Fellow's participation in case conferences, (c) evaluating the Clinical Fellow by professional colleagues and employers, (d) evaluating the Clinical Fellow's work by patients and their parents, and (e) monitoring the Clinical Fellow's contributions to professional meetings and publications, as well as participation in other professional growth opportunities.			
	Date	Site	Activity Observed
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

SECTION C – Certification of Supervisor

CERTIFICATION OF SUPERVISOR

I hereby certify that the preceding information is correct to the best of my knowledge.

_____

Signature of supervisor **Date**

ATTACHMENT A3

APPLICANTS MUST HAVE THIS FORM COMPLETED IF APPLYING BY RECIPROCITY.

CERTIFICATION OF APPLICANT'S LICENSE IN AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY
(Must be completed by licensing agency)

(PRINT OR TYPE)

Our records indicate that _____ was licensed as an
(Applicant's Name)

_____on _____, 20_____. The license was issued Audiologist/Speech-Language Pathologist

on the basis of written examination. _____.
(Name of Examination)

The applicant's score was

Requirements for licensure in Issuing State at the time this license was issued were:
_____.

and are currently: _____.
(Copies of regulations/requirements for licensure at the time of issuance of license and present requirements may be attached as documentation.)

Based on the records of this department, the applicant's license:

(a) ❑ is in good standing, and so far as our records are concerned, the applicant is entitled to endorsement.
(b) ❑ has been disciplined.

Please explain any disciplinary action: _____.
_____.

Date: _____ _____
Name and Title

OPTIONAL: _____
Licensing Agency

(_____) _____ .
Area Code Telephone Number _____
Address

_____
City State Zip Code

(SEAL)

_____ .
Signature (NO STAMP)

FORWARD THIS COMPLETED FORM TO:

Nebraska Department of Health and Human Services
Regulation and Licensure
Credentialing Division
ASLP
P.O. Box 94986
Lincoln, NE 68509-4986